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Business, Transportation and Housing Agency

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IN REPLY REFER TO
FILE NO: 933 0196

January 20, 2004

FINAL REPORT

Nancy Diamond
Vice President and Regulatory Affairs
Managed Health Network, Inc.
1600 Los Gamos Drive, Suite 300
San Rafael, CA 94903

RE: ROUTINE EXAMINATION OF MANAGED HEALTH NETWORK

Dear Ms. Diamond:

Enclosed is the Final Report of the routine examination of the fiscal and administrative affairs of Managed Health Network (the "Plan"), conducted by the Department of Managed Health Care (the Department"), pursuant to Section 1382 (b) of the Knox-Keene Health Care Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on November 14, 2003. The Department received the Plan's response on January 2, 2004.

This Final Report includes a description of the compliance efforts included in the Plan's January 2, 2004 response, in accordance with Section 1382 (c).

Section 13082 (d) states "If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

Please indicate within ten (10) days whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan's response shall be appended, and provide copies (hardcopy and electronically) of those portions of the Plan's

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

response exclusive of information held confidential pursuant to Section 1382 (c), no later than ten (10) days from the date of the Plan's receipt of this letter.

If the Plan requests the Department to append a brief statement summarizing the Plan's response to the report or wishes to modify any information provided to the Department in its January 2, 2004 response, please provide the documentation (hardcopy and electronically) no later than ten (10) days from the date of the Plan's receipt of this letter.

As noted in the attached Final Report, the Plan's response of January 2, 2004 did not fully respond to deficiencies raised in the Preliminary Report issued by the Department on November 14, 2003. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any request for additional corrective action contained in the attached revised Final Report, within 30 days after receipt of the report.

Please file the Plan's response electronically, just as you do for regular licensing filings via the Department's web portal (https://wp.dmhc.ca.gov/efile) under Report/Other, subfolder RUXAM and barcode RX004. Do not file an Execution Page or Exhibit E-1 (Summary of Filing). Please note this process is separate from the electronic financial reporting and is for the response to this report only. Questions or problems related to the electronic transmission of the response should be directed to Angie Rodriguez at (916) 324-9048 or email at arodriguez@dmhc.ca.gov or Ed Cheever at (916) 324-8738 or email at echeever@dmhc.ca.gov. You may also email inquiries to helpfile@dmhc.ca.gov.

In addition, please also email an electronic copy of your response to me at rmartin@dmhc.ca.gov in order to expedite the reporting process. Please feel free to call me at (916) 322-1583 if you have any questions regarding this report.

The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of this letter

Sincerely,

Richard Martin
Supervising Examiner
Division of Financial Oversight

cc: Mark E. Wright, Chief, Division of Financial Oversight
Roslyn R. Mack, Counsel
Barbara Yaklin, Examiner
Kelvin Gee, Examiner

DEPARTMENT OF MANAGED HEALTH CARE

REPORT OF ROUTINE EXAMINATION

MANAGED HEALTH NETWORK

FILE NO.: 933 0196

DATE OF FINAL REPORT: January 20, 2004

SUPERVISING EXAMINER: RICHARD MARTIN
EXAMINER-IN-CHARGE: KELVIN GEE

MANAGED HEALTH NETWORK
BACKGROUND INFORMATION

Date Plan Licensed:	March 10, 1983
Organizational Structure:	Managed Health Network, a California Corporation (the "Company" or "MHN") is a wholly owned subsidiary of Health net, Inc. ("HNI"), formerly Foundation Health Systems, Inc.
Type of Plan:	MHN is a Specialized Health Plan. MHN offers employee assistance program ("EAP") and managed care programs for outpatient and inpatient mental health and chemical dependency services ("Managed Care Programs").
Provider Network:	The Plan has a network of contracting providers. It pays fee-for-service to all providers. MHN offers members a network of Participating Providers that include: psychiatrists, psychologists, clinical social workers, clinical social workers, marriage and family therapists, masters level counselors, chemical dependency, rehabilitation and mental health facilities.
Plan Enrollment:	A total of 2,453,634 enrollees were reported for the month ended November 30, 2003.

FINAL REPORT OF A ROUTINE EXAMINATION OF MANAGED HEALTH PLAN NETWORK

This is the Final Report of a routine examination of the fiscal and administrative affairs of Managed Health Network (the "Plan"), conducted by the Department of Managed Health Care (the "Department") pursuant to Section 1382 (b) of the Knox-Keene Health Care Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on November 14, 2003. The Department received the Plan's response on January 2, 2004.

This Final Report includes a description of the compliance efforts included in the Plan's January 2, 2004 response to the Preliminary Report, in accordance with Section 1382 (c).

We performed an examination of the financial report filed with the Department for the quarter ended March 31, 2003, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions.

Our findings are presented in the accompanying attachment as follows:

Section I.	Financial Report
Section II.	Calculation of Tangible Net Equity
Section III.	Compliance Issues
Section IV	Internal Control Issues

Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any requests for additional corrective action contained in this revised report, within 30 days after receipt of this report.

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

SECTION I. FINANCIAL REPORT

At March 31, 2003, the Plan was in compliance with Financial Reporting requirements of Section 1384, 1345(s) and Rule 1300.45(q). Our routine examination resulted in no material adjustments or reclassifications to the financial report filed with the Department. No response to this section is required from the Plan.

SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

At March 31, 2003 the Plan was in compliance with the TNE requirements of Rule 1300.76. No response to this section is required from the Plan. A copy of the Plan's financial statements can be obtained at the Department's website by typing the link http://wpso.dmhc.ca.gov/fe/search.asp and selecting Managed Health Network on the first drop down menu**.** No response is required to this Section.

CONTINGENT LIABILITIES

At the time of issuance of the Preliminary Report dated November 14, 2003, the legal representation confirmation letter from Philip G. Davis, legal counsel for the Plan's parent Health Net was outstanding.

The Plan was required to provide the legal representation letter as requested during our examination and the most recent estimate of the Plan's total financial exposure as of March 31, 2003 relating to actions against the Plan.

The Plans response included the legal representation letter and open legal matters as of March 31, 2003.

The Department finds that the Plan's compliance efforts are responsive to the corrective actions required by the Department.

Section III. COMPLIANCE ISSUES

A. CLAIMS REIMBURSEMENT

Section 1371 requires a plan to reimburse claims within (30) working days after receipt of the claim, unless the claim or portion thereof is contested by the plan in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.

If an uncontested claim is not reimbursed within the thirty (30) working day period, interest shall accrue at a rate of fifteen percent (15%) beginning with the first calendar day following the thirty (30) working day period. A health care service plan should automatically include in its payment of the claim all interest that has accrued pursuant to this section without requiring the claimant to submit a request for the interest amount. Any plan failing to comply with this requirement should pay the claimant a ten-dollar ($10) fee.

As previously indicated in the Department's Final Reports of its routine and nonroutine follow-up financial examinations, dated February 27, 2001 and October 9, 2003, the plan was cited for failure to pay claims within the timeframe required by Section 1371 and failure to include the applicable interest and penalties mandated by the statute. These deficiencies were referred to the Department's Office of Enforcement and administrative penalties were assessed.

As Part of our current routine examination, we reviewed paid, pended, denied, waiting to be processed and payable claims data from June 30, 2002 to March 31, 2003. We selected a sample of claims from this data for our review. Our exam also included a review of claims data from April 1, 2003 through October 21, 2003 to determine compliance with Section 1371.

Based on our review, the following was disclosed:

1. Claims were denied beyond 30-working-days from the date of receipt of the claim.

2. Certain claims were reimbursed beyond 30-working-days and all included interest payments. However, the Plan incorrectly calculated interest owed for a number of those claims that were paid late. The Plan calculates interest owed manually, in certain cases interest payments were calculated higher than owed and others were lower.

The Plan was required to describe procedures implemented that ensure all claim denials are within the statutory requirements of Section 1371 and to comply with the guidelines set forth in Rule 1300.71. The Plan was to indicate the management position responsible for the continued implementation of those procedures and a description of the monitoring system implemented to ensure continued compliance.

The Plan was also required to go back and pay the correct interest owed on those claims that were paid late and included the lower interest payments from June 2002 through current. In addition, the Plan was to provide evidence that the correct interest has been paid on the late claims and describe the procedures implemented that insure that all interest payments are calculated in accordance with Section 1371. The Plan was also required to indicate the management position responsible for the continued implementation of these procedures and provide a description of the monitoring system implemented to ensure continued compliance.

The Plan's response included a corrective plan to comply with Section 1371 and the Plan's timeline for going back and paying the correct interest owed on those claims that were paid late and included the lower interest payment from June 30, 2002, through current. The Plan also included its policies and procedures now implemented that ensure all claim denials are within the statutory requirements of Section 1371 and comply with the guidelines set forth in Rule 1300.71, as well as policies and procedures that ensure that all interest payments are calculated in accordance with Section 1371.

The Plan indicated that a report will be generated on a daily basis displaying any DMHC regulated claim that has reached 24 working days and that the Plan now has an automated process for calculating interest; interest is no longer calculated manually. The MHN claims processing system automatically assign interest payment to a claim that has aged beyond 26 working days. The Plan states to assure accurate payment and allow for check cut and mailing, the interest payment is calculated commencing working day 26 from date of receipt allowing 4 grace days for check cut and

mailing. The Vice President of Operations has been identified as the management position responsible for the implementation and monitoring to ensure continued compliance.

The Plan's responses are not fully responsive to the deficiencies cited. The Plan did not provide evidence that the correct interest has been paid on the late claims from 6/30/02 through 3/31/03. The Plan's Corrective Action Plan cites a target date of February 15, 2004.

The Plan is required to provide evidence that the correct interest owed was paid on late claims from June 2002 through current. If additional interest is owed, the Plan must provide evidence that such payments have been made. In addition, please include in your response current samples of the daily report of claims aged 24 days (as described above) the Plan uses to monitor compliance with Section 1371 and Rule 1300.71.

B. CLAIMS LIABILITY

Rule 1300.77.2 requires a plan to calculate the estimate of incurred and unreported claims (IBNR) pursuant to a method held unobjectionable by the Director. The amount required by Rule 1300.77.1 to be accrued in the plan's books and records must equal the estimated total of all claims incurred but not yet received as of the end of the months calculated in working papers, schedules or reports prepared in support of the method.

For quarter ended March 31, 2003, the plan was adequately accrued for claims liability. However, for the month ended April 30, 2003 the plan decrease its IBNR liability from $18.7 million to $13.7 million with no apparent change to its business operations or enrollment during this period.

At quarter ended September 30, 2002, the Plan reported a TNE deficiency of $2.1 million. The Department sent the Plan a letter, dated November 20, 2002, requesting further information regarding this deficiency. The Plan's response letter, dated December 20, 2002, included Plan representations stating that the TNE deficiency occurred because of a reevaluation of the adequacy of the Plan's IBNR liability accrual (resulting in a substantial increase in the IBNR liability accrual) and adverse underwriting relating to the Plan's business with its affiliate, Health Net of California, Inc.

The Plan was required to submit a detailed written explanation and provide supporting documentation to substantiate the significant decrease in IBNR liability reported to the Department from March 31, 2003 to April 30, 2003. The Plan was requested to provide detailed descriptions of any changes to the Plan's business operations that would warrant the release of IBNR liability reserves as reported and any deviations for the Plan's response to the Department's November 20, 2003 letter addressing the previous under-accrual of IBNR claims liability.

The Plan responded to the Department requirements as follows:

April 30, 2003 Reserves

The decrease in IBNR liability from March 31, 2003, to April 30, 2003, was due to an actuarial evaluation showing that the claims run out experience in most lines of business appeared to be emerging favorably, especially in 1st quarter 2003. This claims valuation was performed by new actuarial management at MHN that was hired in April of 2003. Based upon updated claims analysis and trend assumptions, the Plan's actuarial management determined that it was no longer necessary to maintain the greatly increased IBNR liability reserve levels that were set in November of 2002. Over the past seven months, from May 2003 through November 2003, this updated estimate of claims experience and reserves has been proven to be accurate, as MHN's financial situation has continued to improve through the course of 2003.

November 30, 2002 Reserves

Based upon their current information at the time, the prior actuarial management increased the total unpaid claim liability from $9.4 million at the end of August 2002 to $15.1 million at the end of November 2002, an increase of 61%. The reasons for that increase were addressed in the December 20, 2002 response to the Department, which discussed in detail why the actuarial management believed that IBNR in prior periods was understated. As mentioned above, the financial picture and forecast of claims experience based upon the more recent data available in May 2003 led the new actuarial management to conclude that IBNR reserve levels could be reduced.

The Plan's response does not fully respond to the Department's concern with the Plan's IBNR reserves. The Plan was required to provide supporting documentation of its written explanation. The supporting documentation should consist of detailed lag studies for the appropriate time period, any actuarial reports, and hindsight analyses of claims paid.

In your response to this report, provide detailed supporting documentation to substantiate the significant reductions of the IBNR reserve levels reported to the Department.

C. CLAIM PRICING

Section 1379(a) requires that every contract between a plan and a provide of health care services be in writing, and shall set forth that in the event the plan fails to pay for health care services as set forth that in the event the plan fails to pay for healthcare services as set forth in subscriber contract, the subscriber or enrollee shall not be liable to the provide for any sums owed by the plan.

Our routine examination disclosed that the payment rates used to adjudicate claims did not match the rates per the Schedule of Compensation in certain written provider contracts. Some compensation rates paid to providers were higher than the rates disclosed in the written provider contracts. The Plan was not updating written provider contracts for increased rates, and as a result, the Department was unable to determine if providers are paid in compliance with the written contract.

The Plan was required to submit policies and procedures implemented that ensure provider rate schedules per the Plan's claims system reflect the written provider contracts. The Plan was also required to state the management position responsible for the continued implementation of those procedures and a description of the monitoring system implemented to ensure ongoing compliance.

The Plan's response included a copy of "Documentation of Increases to Practitioners Rates Policy and Procedure" and indicated that the Vice president, Professional Relations for there continued implementation. The Plan also stated they are audited regularly, at least quarterly, by commercial clients, health plan partners and internal auditors who review claim payments against the rates that are contained in the provider file.

The Plan's response does not fully respond to the citied deficiency. The Plan's policy and procedures for documenting the changes to practitioner rates is dated December 1, 2001 and our examination found these policy and procedures were not implemented on a consistent basis.

In your response to this report, provide assurances that the Plan will adhere to the submitted policy and procedures and a description of the monitoring system implemented to ensure ongoing compliance.

D. FIDELITY BOND

Rule 1300.76.3(a) requires each plan to maintain, at all times, a fidelity bond covering each officer, director, trustee, partner and employee of the plan, whether or not they are compensated. The fidelity bond may be either a primary commercial blanket bond or a blanket position bond written by an insurer licensed by the California Insurance Director, and it shall provide for 30 days' notice to the Director prior to cancellation.

The fidelity bond presented for our review did not include an endorsement stating that the bond covers each officer, director, trustee, partner and employee of the plan, whether or not they are compensated. Non-compensated directors and trustees are compensated officers are not covered under the policy.

The Plan was required to submit evidence that the fidelity bond fully complies with the requirements of Rule 1300.76.3. The Plan was also required to state the management position responsible for compliance and a description of the monitoring system implemented to ensure continued compliance.

The Plan response included a letter from the Plan's insurance carrier, AIG that confirms coverage whether or not the directors, trustees and officers are compensated provided they are performing acts within the scope of the usual duties of an employee.

Additionally, the letter states a loss by a director, trustee, or non-compensated officer not performing usual duties of an employee would not be covered under the employee dishonesty section of the policy, the carrier confirmed that such loss would be covered under the

"Dissolution" definition of the policy, which covers the following: "the actual destruction or disappearance of money or securities; or wrongful abstraction of assets resulting from theft by any natural person other than an employee."

The Plan response states the management position responsible for compliance is the Risk Manager.

The Department finds that the Plan's compliance efforts are responsive to the corrective actions required by the Department.

SECTION IV. INTERNAL CONTROL ISSUES

ALLOWANCE FOR UNCOLLECTABLE PREMIUM

Our examination disclosed that the Plan's allowance for uncollectable premium receivables did not fully reserve for all uncollectable premiums as March 31, 2003. However, the additional reserve was determined to be immaterial and no adjusting journal entry was made to the balance sheet.

The Plan was required to describe the procedures implemented to ensure the proper accrual of an allowance for uncollectable premiums. The Plan was also required to provide the date those procedures were implemented, the management position responsible for the oversight of the procedures, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

The Plan's response stated its policy regarding the accounts receivable allowance is to fully reserve for any amount over 120 days. The Plan sent in evidence of this allowance was made in July of 2003. The Plan further stated that the policy was effective January 1, 2003. This procedure is reviewed monthly by the Manager of Accounting, and reviewed quarterly by the Corporate Controller.

The Department finds that the Plan's compliance efforts are responsive to the corrective actions required by the Department.